



Adult Child Certification (Ages 26 - Up to Age 28)

Department of Human Resources
 115 Medical Sciences Building
 3640 Colonel Glenn Hwy.
 Dayton, OH 45435-0001
 Tel: (937) 775-2120 Fax: (937) 775-3040

I hereby request medical coverage under the Wright State University self-insured plan for my adult child indicated below.

Employee Information:

| | | |
|-------------|-----------------------------|---|
| Last Name: | First Name, Middle Initial: | University ID: |
| Department: | | Effective Date of Adult Child Enrollment: |

Adult Child Information:

| | | |
|---|-----------------------------|--|
| Last Name: | First Name, Middle Initial: | Social Security Number: |
| Relationship to Employee: | | Date of Birth: |
| | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address: | City: | State: Zip Code: |
| Adult Child's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated | | |

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|---|---|-------------------------|----------------------|
| Full-Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No | Academic Calendar: <input type="checkbox"/> Quarter <input type="checkbox"/> Semester | Number of Credit Hours: | Name of Institution: |
|---|---|-------------------------|----------------------|

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|---|--|--|---------------------|
| Is this Adult Child Employed?: <input type="checkbox"/> Yes <input type="checkbox"/> No | Employment Status: <input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time | Does the employer offer health insurance for which the Adult Child is eligible?: <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Employer: |
| Employer Address: | | City: | State: Zip Code: |

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| Is this Adult Child covered under any other group medical insurance?: <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who is the other insurance carrier?: |
| Policy Number: | Policy Holder: |
| Is this Adult Child eligible for Medicare or Medicaid?: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

I certify that all information provided on this form is correct to the best of my knowledge and authorize release of any information requested by Wright State University or Anthem Blue Cross Blue Shield with respect to this Certification. I will provide Wright State University and or Anthem Blue Cross Blue Shield with certification of continuing eligibility annually or when requested. I also understand that my Adult Child's coverage will automatically terminate if response is not received within 60 days from the date of request.

I understand that coverage terminates when the Adult Child no longer meets the criteria of Adult Child noted within our Plan eligibility provision and no later than the end of the month in which the Adult Child reaches age 28. I agree to notify Wright State University immediately when the Adult Child no longer meets the Adult Child eligibility provisions.

I understand that, upon enrollment of the Adult Child, Wright State University will adjust monthly Plan contributions to reflect the surcharge for that coverage and that the surcharge will be paid by me as my responsibility to pay as an after tax deduction.

| | | | |
|--|------|--|----------------|
| Employee Signature | Date | Adult Child Signature | Date |
| www.wright.edu/hr | | hr_benefits@wright.edu | (937) 775-2120 |